SALMON RIVER CENTRAL SCHOOL DISTRICT
SUPERINTENDENT'S OFFICE

637 Co. Rt. 1, Fort Covington, New York 12937 • Tel: (518) 358-6600 • Fax (518) 358-2145

PHYSICIAN AND PARENT AUTHORIZATION FOR

ADMINISTRATION OF MEDICATION IN SCHOOL

A. ***To be completed by Physician:***

I request that my patient, as listed below, receive the following medication:

Name of Student ____________________________________DOB________________

MEDICATION________________________________DOSAGE___________________

FRQUENCY/TIME TO BE TAKEN_______________________

ROUTE OF ADMINISTRATION________________________

Possible side effects and adverse reactions (if any):

**Diagnosis___________________________________ *ICD10 code_______________

Physician's Signature__________________________________Date:_________________

Address:____Phone:__________________

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Diagnosis and ICD 10 code **MUST be included

B. ***To be completed by parent or guardian*:**

I request that my child ____________________________________DOB___________

receive the medication as prescribed above by our physician. The medication is to be furnished by me in the properly labeled container from the pharmacy.

Parent or Guardian signature: _____________________________Date:_______________

Phone: __________________________________Work Number:___________________